

**ACCIDENT/INJURY INVESTIGATION REPORT**

*Section I of this form must be completed within 24 hours of* ***all*** *occupational injuries, illnesses, or accidents involving ER/St James Mercy Hospital’s temporary or full-time employees and submitted to Human Resources*

*Retain this form in the branch OSHA/Workers' Compensation file for five years from the date of the incident or five years after the workers' compensation claim is closed,* ***whichever is longer. Form is equivalent to OSHA's form 301.***

*Section I – ACCIDENT/INJURY INVESTIGATION REPORT*

*Completed by Employee with Manager/Supervisor:*

DIRECTIONS: If employee needs URGENT medical care, please obtain the written statement as soon as possible following treatment. Please write clearly. FORM MUST CONTAIN THE EMPLOYEE’S SIGNATURE.

EMPLOYEE Full NAME: \_\_\_\_\_

Injured employee’s job title: \_\_\_\_\_

Department: \_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Date Hired\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Male\_\_\_\_ Female\_\_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TIME EMPLOYEE STARTED WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPROXIMATE TIME OF INJURY: \_\_\_\_\_\_\_\_\_\_\_

Was the Employee treated in an Emergency room?  Yes  No

If yes, please describe the type of treatment received:

\_\_\_\_\_

\_\_\_\_\_

Name of facility where it was provided:

Physician or other health care professional \_\_\_\_\_

Was Employee hospitalized overnight as an in-patient?  Yes  No

Did the injury/illness result in lost time or restricted duty?  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

***Section I - ACCIDENT/INJURY INVESTIGATION REPORT*** *cont’*

*Completed by Employee with Manager/Supervisor:*

WHEN DID YOU FIRST REPORT THIS, AND TO WHOM WAS IT REPORTED? \_\_\_\_\_

\_\_\_\_\_

IF YOU DID NOT REPORT THIS IMMEDIATELY WHEN IT OCCURRED, PLEASE EXPLAIN WHY: \_\_\_\_\_

\_\_\_\_\_

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? \_\_\_\_\_

\_\_\_\_\_

WHAT HAPPENED?

DESCRIBE EXACTLY HOW THIS INJURY OCCURRED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHAT WAS THE INJURY OR ILLNESS ( tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain" or "sore"):

\_\_\_\_\_

\_\_\_\_\_

What Object or substance directly harmed the employee?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARK THE AREA ON THE ILLUSTRATION BELOW WHERE YOU ARE

HAVING THE SYMPTOMS YOU DESCRIBED ON THE INJURY REPORT

 

   

PALM SIDE TOP OF FOOT

BACK SIDE BOTTOM OF FOOT

\*Note: Please attach photographs, drawings, statements, and any additional data to report.

Date: Employee Signature (Required): \_\_\_\_\_

***Section I - ACCIDENT/INJURY INVESTIGATION REPORT*** *cont’*

*Completed by Employee with Manager/Supervisor:*

WAS A SAFETY DEVICE REQUIRED?  YES  NO

WERE YOU TRAINED PROPERLY ON HOW TO USE THE SAFETY DEVICE?  YES  NO

DID YOU USE THE SAFETY DEVICE?  YES  NO

IF APPLICABLE, WHAT SAFETY DEVICE WAS REQUIRED AND/OR USED? \_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER EXPERIENCED THE SAME OR SIMILAR SYMPTOMS DESCRIBED ABOVE, OR HAD A PRIOR INJURY TO THE SAME PART OF YOUR BODY?  YES  NO

*This information allows us to determine your pre-existing status. This does not disqualify you from being entitled to care for any current injury or any aggravation to an underlying pre-existing condition. It is in your best interest to provide this information at the time of injury.*

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHO WAS YOUR MEDICAL TREATMENT PROVIDER FOR THIS PRIOR CONDITION/INJURY? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

APPROXIMATELY WHEN DID THIS PRIOR TREATMENT OR INJURY TAKE PLACE? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that this statement will be considered part of the investigation process and that I may be called upon to testify or provide written or verbal clarifying statements. The statement I have provided is an accurate account of the case to the best of my knowledge.

Date: Employee Signature (Required): \_\_\_\_\_

***Section I - ACCIDENT/INJURY INVESTIGATION REPORT cont’***

*Completed by Employee with Manager/Supervisor:*

| Contributing Factors | |
| --- | --- |
| Check all contributing factors to the accident in the boxes below. | |
| Injury and Property Damage  Distraction  Failure to secure (locking, tightening, closing)  Failure to use personal protective equipment  Failure to warn (signs, barricades, alarms)  Horseplay  Improper activation  Improper body mechanics  Improper loading  Improper placement  Improper position for task  Improper safety equipment  Making safety devices inoperable  Operating equipment without authority  Operating at improper speed (hurrying, speeding)  Removing safety devices  Servicing equipment in operation/no lockout  Unsafe driving  Using defective equipment  Using equipment improperly  Under influence of drugs or alcohol  Confined space entry (tanks or vessels)  Congested or restricted area/activity  Defective tools, equipment, or materials  Excessive noise  Explosion  Fire  Hazardous environmental conditions (spills, gases, dusts, smokes, fumes, vapors)  Hazardous personal attire  High or low temperature exposure  Icy conditions  Inadequate guards or barriers  Inadequate lighting  Inadequate protective equipment  Inadequate ventilation  Inadequate warning system (alarms, barricades, signs)  Poor housekeeping; disorder  Projecting hazard (pole, angle iron, etc.)  Pinch point (gears, pulleys, belts, etc.)  Road conditions  Safety device inoperable  Slippery conditions  Hazardous storage/stacking  Other (explain): | Vehicle Accident  Following too closely  Improper turning  Improper backing  Improper lane change  No/improper pre-trip  Left of center  Failure to secure equipment  Improper use of mirrors  Improper use of turn signals  Improper use of lights  Improper use of horn  Improper use of emergency equipment  Misjudged clearance  Failed to yield right of way  Alcohol - under influence  Drugs - under influence  Disregarding traffic signals/signs  Unsafe speed for conditions  Improper passing  Obstructing traffic  Improper load  Failure to use safety equipment  Improper parking  Defective brakes  Worn/smooth tires  Defective lights (vehicle)  Inadequate lighting (roadway)  Defective windshield wipers  Defective steering mechanism  Road construction  Loose road surface materials  Holes/ruts in road  Standing water  Defective equipment tools  Icy road conditions  Wet road conditions  Inclement weather  Parked/stopped vehicle  Overloaded vehicle  Obstruction to view (signs, trees, buildings., etc.)  Glare  Fog  Smoke  Other (explain): |
| Provide details for all contributing factors checked above. | |

*Section II – ACCIDENT/INJURY INVESTIGATION REPORT*

*Completed by witnesses and/or co-workers:*

CO-EMPLOYEE/WITNESS STATEMENT

DIRECTIONS: Please write clearly. FORM MUST CONTAIN THE SIGNATURE OF THE PARTY SUPPLYING THE STATEMENT. Make copies if additional statements are required.

STATEMENT REGARDING: \_\_\_\_\_ (name of injured employee)

WITNESS NAME: \_\_\_\_\_

WITNESS JOB TITLE: \_\_\_\_\_

WHAT IS YOUR KNOWLEDGE REGARDING THIS INJURY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(USE BACK OF FORM IF NECESSARY)

PLEASE LIST ANY OTHER WITNESSES OR INDIVIDUALS THAT MAY HAVE INFORMATION RELATIVE TO THIS INVESTIGATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that this statement will be considered part of the official investigation and that I may be called upon to testify or provide written or verbal clarifying statements. The statement I have provided is an accurate account of the case to the best of my knowledge.

Date: Signature (Required): \_\_\_\_\_

Phone: Home Address: \_\_\_\_\_

*Section III – ACCIDENT/INJURY INVESTIGATION REPORT*

*Completed by Employee with Manager/Supervisor:*

|  |  |  |
| --- | --- | --- |
| Root Causes | | |
| Check all applicable causal factors (root cause) that, if corrected, would prevent recurrence of the same or similar injury/illness, accident, or near miss. | | |
| Personal Factors  Improper work habits  Lack of knowledge  Lack of skill  Physical limitations  Pre-existing condition | Job Factors | |
| Abuse or misuse  Improper equipment/tool design  Inadequate engineering  Inadequate leadership/supervision  Inadequate maintenance  Inadequate purchasing standards  Inadequate training | Inadequate work procedures  Overtime  Promotional (sales)  Unusual work load  Wear and tear  Not employee’s regular occupation  Not employee’s regular work hours |
| Provide details for all root causes checked above. | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Corrective Action Plan | | | | | | | |
| Check all actions needed to eliminate recurrence of the same or similar accident. | | | | | | |
| Change Procedures | | | Change Behavior | | Make Work Improvements | |
| Modify housekeeping procedures  Develop safer work procedures  Eliminate unsafe activity procedures  Communicate job procedures  Review employee skills relating to job  Review/improve maintenance of tools/  equipment  Redesign work process  Require additional training/orientation  Other | | Prevent/correct employees bypassing safety devices  Prevent/correct operation of unsafe equipment  Act to enforce use of protective equipment  Act to prevent/correct unsafe speed or improper operation  Act to prevent/correct employee doing unsafe work  Correct the disregard of unsafe work conditions  Enforce/use correct safety procedure  Act to prevent on premise intoxication/other  Take action to address general health problem  Take disciplinary action  Other | | | Modify design of work station  Modify lighting  Modify ventilation  Modify flow of materials  Provide better tools and equipment  Replace defective equipment  Safeguard against failure of safety devices  Prevent/alleviate unguarded hazard  Prevent/alleviate crowded conditions  Prevent/alleviate slippery/wet conditions  Take actions to prevent blind corners  Prevent/alleviate unsafe conditions/acts  Other | |
| Provide details for all corrective actions checked above. | | | | | | |
| No. | Description of Corrective Action | | | Assigned To | | Completion Date |
| 1. |  | | |  | |  |
| 2. |  | | |  | |  |
| 3. |  | | |  | |  |
| Investigating Supervisor's Signature | | | | Date: | | |

|  |  |
| --- | --- |
| Risk | |
| If this accident went uncorrected and happened again, how severe would it be?  Major  Serious  Minor | If this accident went uncorrected and happened again, what is the probability it would reoccur?  Frequent  Occasional  Seldom |

|  |  |
| --- | --- |
| Investigation Conducted by: | |
| Name | Title |
| Signature | Date |

Arrange meeting with Accident Investigation Committee for further review: